ARLINGTON CENTRAL SCHOOL DISTRICT
HEALTH HISTORY (To be completed by parent/guardian)

Student Name _____ Sex _____ Date of Birth ____/____/_____
(Last, First, Middle Initial)

I. Life Threatening Allergic Conditions: (Check all that apply.)

[ ] Severe allergic reaction to Bee Stings, other insects:_____
[ ] Severe reaction to Nuts, Peanuts: _____
[ ] Severe reaction to other Food Products: _____
[ ] Other severe allergies affecting school: _____

Please indicate any of your child's symptoms which would indicate a severe allergy: (Local swelling does *not* indicate a severe allergic reaction.) [ ] Itching and/or tightness in the throat, hoarseness [ ] Itching or swelling of the eyes, lips, tongue or mouth
[ ] Shortness of breath, coughing, and/or wheezing [ ] "Thready pulse", "passing out"/loss of consciousness
[ ] Hives

Has your physician prescribed an Epi-Pen or other medicine for a severe life threatening allergy? [ ] Yes* [ ] No
Specify medication: _____ * If you answered "Yes", it is strongly advised that he/she have this medication in school; it is **required** for interscholastic sports, (grades 7 – 12), with a physician's order specifying that he/she is able to "self-administer" it. Carefully read the ***School Medication Policy*** below.

II. Health Conditions: **Has your child been diagnosed by a physician with any of the following? Check "Yes" or "No". Provide dates and details for all items checked "Yes".**

Yes	No	Condition	Details/Dates
		Attention deficit: ___ ADD or ___ ADHD Date diagnosed _____ Meds: ___ Yes ___ No	
		Allergies to medications	
		Allergies (environmental or seasonal)	
		Asthma/Reactive Airway Uses an inhaler? ___ Yes ___ No Uses a nebulizer? ___ Yes ___ No If your child uses an inhaler, it may be advisable to have this medication in school; it is **required** for interscholastic sports, (grades 7–12), with a physician's order specifying that he/she is able to "self administer" it. Carefully read the ***School Medication Policy*** below.	
		Autism/PDD: ___Autism or ___Aspergers or ___PDD-NOS (not otherwise specified)	
		Behavior problem	
		Bleeding disorder	
		Bowel or digestive problem	
		Cancer, Type: _____ Date diagnosed _____	
		Cerebral Palsy	
		Chromosomal disorder: ___ Down's syndrome ___ Other – specify →	
		Cleft lip/palate	
		Cystic Fibrosis	
		Dental problem	
		Depression	
		Diabetes: Date diagnosed _____ Insulin Dependent: ___ Yes ___ No	
		Eating disorder: ___Anorexia ___ Bulemia	
		Emotional disorder	
		Growth problems	
		Heart problem: specify →	
		Hepatitis, Type: _____ Date diagnosed _____	
		Hernia	
		High blood pressure	
		Hospitalizations: specify →	
		Immunodeficiency disease	
		Kidney or urinary problem	
		Lyme disease	
		Muscular disorder	

Yes	No	Condition	Details/Dates
		Migraine headaches	
		Nutritional/weight problem	
		Orthopedic problem (bone, joint)	
		Pregnancy	
		Rheumatoid Arthritis	
		Scoliosis/abnormal spinal curve: Date of diagnosis _____ Date of last evaluation _____	
		Seizure disorder, Type _____ Date of last seizure:_____ Meds: ___ Yes ___ No. Medication _____ (Please provide physician documentation of diagnosis.)	
		Self Harm/Mutilation	
		Sickle cell disease	
		Skin condition	
		Spina bifida	
		Substance abuse (alcohol, drugs, tobacco)	
		Suicide risk or attempt	
		Surgeries: specify →	
		Thyroid disorder	
		Tics or twitches	
		Tourette's syndrome	
		Tuberculosis	
		Other	

Yes	No	
		My child is healthy and has no special health needs.

Yes	No	HEARING	
		Hearing loss: [ ] Right - ___Mild ___ Moderate ___Severe [ ] Left - ___Mild ___ Moderate ___Severe	Hearing loss due to _____ Last evaluation _____
		Hearing aid [ ] Right [ ] Left	

Yes	No	VISION
		Color deficiency
		Legally blind
		Vision problem/Eye defect _____ Last eye exam _____
		Wears glasses [ ] All the time [ ] For distance only [ ] For reading only [ ] For sports
		Wears contact lenses

III. Medications: (Include prescription and over-the-counter medication)

Name_____ **Used to Treat**_____

_____ _____

_____ _____

SCHOOL MEDICATION POLICY: If your child has a medical condition that requires medication in school, a written physician's order is required. No medication may be carried in school by a student; this applies to medications "over the counter" as well. The only exceptions are for those students with asthma inhalers and EpiPens whose order specifies that they may "self-carry/self- administer" their medication. All medication must be delivered to the school Health Office by the parent/ guardian with the physician's original order and written parental permission. Medication order forms are available through the Health Office.

IV. Special Needs

Are there any other medical diagnoses or disabling conditions that might require a modification in your child's activities at school?

[ ] Yes* [ ] No Specify: _____

_____

*** Any condition that would prevent full participation in educational programs (including physical education) requires physician documentation before modifications can be considered.**

I understand that if my child's health status changes during the school year, I will provide the Health Office with updated information.

Parent/Guardian Signature _____ Date _____